		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0019596

Facility Name: Alden Morrow Rehab & HCC

Address: 5001 S. Michigan Ave. (Number) Chicago (City) 60615 (Zip Code)

County: Cook

Telephone Number: (773) 286-3883 **Fax #** (773) 286-3743

IDPA ID Number: 36 - 2814943

Date of Initial License for Current Owners: 11/01/76

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven M. Kroll **Telephone Number:** (773) 286-3883

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Steven M. Kroll

(Title) Chief Financial Officer

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	192	Skilled (SNF)	192	70,080	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	192	TOTALS	192	70,080	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,292	62	694	9,048	8
9	SNF/PED					9
10	ICF	26,256	32	27	26,315	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,548	94	721	35,363	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 50.46%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 01/04/1976

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 18 and days of care provided 643

Medicare Intermediary AdminisStar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	169,720	25,970	6,500	202,190	998	203,188		203,188			1
2	Food Purchase		189,913		189,913	(20,129)	169,784	(10,592)	159,192			2
3	Housekeeping	105,615	19,023		124,638	476	125,114		125,114			3
4	Laundry	40,585	12,093		52,678		52,678		52,678			4
5	Heat and Other Utilities			157,804	157,804		157,804	942	158,746			5
6	Maintenance	38,460		85,687	124,147	11,109	135,256	10,480	145,736			6
7	Other (specify):*											7
8	**TOTAL General Services**	354,380	246,999	249,991	851,370	(7,546)	843,824	829	844,653			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	852,304	41,777	4,608	898,689	2,131	900,820	(5,858)	894,962			10
10a	Therapy											10a
11	Activities	44,762	2,452	3,028	50,242	124	50,366		50,366			11
12	Social Services	32,726			32,726		32,726		32,726			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	929,792	44,229	19,636	993,657	2,255	995,912	(5,858)	990,054			16
	C. General Administration											
17	Administrative	144,359			144,359		144,359		144,359			17
18	Directors Fees											18
19	Professional Services			660,063	660,063		660,063	(614,964)	45,099			19
20	Dues, Fees, Subscriptions & Promotions			33,254	33,254	(7,226)	26,028	(15,033)	10,995			20
21	Clerical & General Office Expenses	256,423	13,908	113,399	383,730	7,334	391,064	22,866	413,930			21
22	Employee Benefits & Payroll Taxes			249,332	249,332	16,292	265,624	45,849	311,473			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,293	2,293		2,293	7,728	10,021			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			50,364	50,364		50,364		50,364			26
27	Other (specify):* **bad debt**			25,990	25,990		25,990	(25,989)	1			27
28	**TOTAL General Administration**	400,782	13,908	1,134,695	1,549,385	16,400	1,565,785	(579,543)	986,242			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,684,954	305,136	1,404,322	3,394,412	11,109	3,405,521	(584,571)	2,820,950			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Alden Morrow Rehab & HCC #0019596 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation					71,946	71,946	80,143	152,089			30
31	Amortization of Pre-Op. & Org.							973	973			31
32	Interest			144,233	144,233		144,233	22,076	166,309			32
33	Real Estate Taxes			226,780	226,780		226,780	2,628	229,408			33
34	Rent-Facility & Grounds			526,424	526,424		526,424	(526,018)	406			34
35	Rent-Equipment & Vehicles			8,598	8,598		8,598	11,498	20,096			35
36	Other (specify):* Mortg. Insurance			83,055	83,055	(83,055)		8,150	8,150			36
37	**TOTAL Ownership**			989,090	989,090	(11,109)	977,981	(400,550)	577,431			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		31,881	53,906	85,787		85,787	(28,585)	57,202			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		27		27		27	(27)				41
42	Provider Participation Fee			105,120	105,120		105,120		105,120			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		31,908	159,026	190,934		190,934	(28,612)	162,322			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,684,954	337,044	2,552,438	4,574,436		4,574,436	(1,013,733)	3,560,703			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	66,942	30		9
10	Interest and Other Investment Income	(140,406)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(31)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(400)	32		18
19	Entertainment				19
20	Contributions	50	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(25,989)	27		24
25	Fund Raising, Advertising and Promotional	(9,959)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,825)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (111,618)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(515,693)		34
35	Other- Attach Schedule	(386,422)	pg 5a	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (902,115)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,013,733)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39			x			39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Alden Morrow Rehab & HCC

ID# 0019596

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	LEGAL FEES-COLLECTIONS	$ (880)	21	1
2	BACK OUT IL. HEALTHCARE ASSOC PAC FEES	(845)	20	2
3	BACK OUT MARKETING CONSULTANT	(2,714)	20	3
4	BACK OUT CLOTHING GIFT SHOP	(27)	41	4
5	MORTGAGE INTEREST	132,499	32	5
6	MIP INSURANCE	8,150	36	6
7	ELIMINATE RENT DUE TO SALE/LEASEBACK	(526,424)	34	7
8	Record add'l def maint exp to correct amt.	4,606	6	8
9	Correct depreciation costs to correct detail	484	30	9
10	Back out utility late fee	(1,272)	5	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(386,422)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(31)	0	0	(10,561)	0	0	0	0	0	0	0	(10,592)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(1,272)	0	2,213	0	0	0	0	0	0	0	0	942	5
6	Maintenance	4,606	0	5,896	0	0	0	(22)	0	0	0	0	10,480	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	3,303	0	8,109	(10,561)	0	0	(22)	0	0	0	0	829	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	(5,560)	(298)	0	0	0	0	0	0	(5,858)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	(5,560)	(298)	0	0	0	0	0	0	(5,858)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(614,964)	0	0	0	0	0	0	0	0	(614,964)	19
20	Fees, Subscriptions & Promotions	(15,293)	0	260	0	0	0	0	0	0	0	0	(15,033)	20
21	Clerical & General Office Expenses	(880)	0	16,121	6,901	724	0	0	0	0	0	0	22,866	21
22	Employee Benefits & Payroll Taxes	0	0	45,734	0	115	0	0	0	0	0	0	45,849	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	7,728	0	0	0	0	0	0	0	0	7,728	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(25,989)	0	0	0	0	0	0	0	0	0	0	(25,989)	27
28	**TOTAL General Administration**	(42,162)	0	(545,121)	6,901	839	0	0	0	0	0	0	(579,543)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(38,858)	0	(537,012)	(9,220)	541	0	(22)	0	0	0	0	(584,571)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	67,426	0	12,564	0	153	0	0	0	0	0	0	80,143	30
31	Amortization of Pre-Op. & Org.	0	0	967	0	0	6	0	0	0	0	0	973	31
32	Interest	(8,307)	0	30,174	0	120	89	0	0	0	0	0	22,076	32
33	Real Estate Taxes	0	0	2,591	0	37	0	0	0	0	0	0	2,628	33
34	Rent-Facility & Grounds	(526,424)	0	406	0	0	0	0	0	0	0	0	(526,018)	34
35	Rent-Equipment & Vehicles	0	0	11,498	0	0	0	0	0	0	0	0	11,498	35
36	Other (specify):*	8,150	0	0	0	0	0	0	0	0	0	0	8,150	36
37	**TOTAL Ownership**	(459,155)	0	58,200	0	310	95	0	0	0	0	0	(400,550)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(2,145)	(4,542)	(21,898)	0	0	0	0	0	(28,585)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(27)	0	0	0	0	0	0	0	0	0	0	(27)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(27)	0	0	(2,145)	(4,542)	(21,898)	0	0	0	0	0	(28,612)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(498,040)	0	(478,812)	(11,365)	(3,691)	(21,803)	(22)	0	0	0	0	(1,013,733)	45

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	employee benefits	$	Alden Management Services		$ 45,734	$ 45,734	15
16	V	19	profess. Fees	622,080	Alden Management Services		7,116	(614,964)	16
17	V	21	g & a		Alden Management Services		16,121	16,121	17
18	V	5	utilities		Alden Management Services		2,213	2,213	18
19	V	6	maintenance		Alden Management Services		5,896	5,896	19
20	V	24	auto/travel		Alden Management Services		7,728	7,728	20
21	V	20	subscriptions/etc		Alden Management Services		260	260	21
22	V	30	depreciation		Alden Management Services		12,564	12,564	22
23	V	31	amortization		Alden Management Services		967	967	23
24	V	33	real estate tax		Alden Management Services		2,591	2,591	24
25	V	34	rent		Alden Management Services		406	406	25
26	V	35	rent-equip/vehicles		Alden Management Services		11,498	11,498	26
27	V	32	interest		Alden Management Services		30,174	30,174	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 622,080			$ 143,268	$ * (478,812)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Tube feeding	$ 20,140	Pyramid Health Care Services	100.00%	$ 9,579	$ (10,561)	15
16	V	10	Nursing supply	7,330	Pyramid Health Care Services		1,770	(5,560)	16
17	V	39	Per diems/other supplies	5,232	Pyramid Health Care Services		3,087	(2,145)	17
18	V	21	General & admin		Pyramid Health Care Services		6,901	6,901	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 32,702			$ 21,337	$ * (11,365)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Drugs	$ 12,886	Foum Extended Care II	100.00%	$ 9,879	$ (3,007)	15
16	V	10	House stock	1,276	Foum Extended Care II		978	(298)	16
17	V	39	IV	6,578	Foum Extended Care II		5,043	(1,535)	17
18	V	22	Employee benefits		Foum Extended Care II		115	115	18
19	V	21	G & A		Foum Extended Care II		724	724	19
20	V	32	Interest		Foum Extended Care II		120	120	20
21	V	33	Real estate taxes		Foum Extended Care II		37	37	21
22	V	30	Depreciation		Foum Extended Care II		153	153	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 20,740			$ 17,049	$ * (3,691)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Therapy	$ 49,955	Community Physical Therapy	100.00%	$ 28,057	$ (21,898)	15
16	V	32	Interest		Community Physical Therapy		89	89	16
17	V	31	Amortization		Community Physical Therapy		6	6	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 49,955			$ 28,152	$ * (21,803)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		6	maintenance expense	$ 7,502	Alden Bennett Constuction	100.00%	$ 7,480	$ (22)	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 7,502			$ 7,480	$ * (22)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd Schlossberg a.	President	Chief Executive	100.00	350,840	1.364	3.41	SALARY	$ 12,373	17-1	1
2	Lauren Magnusson b.	Nurse coordinator	nursing admin.	0.00	88,588	1.364	3.41	SALARY	3,124	17-1	2
3	Terry Magnusson c.	Maint. Supervisor	construct/mainten	0.00	82,893	1.364	3.41	SALARY	2,923	17-1	3
4											4
5											5
6											6
7	a. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										7
8	b. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is a nurse coordinator.										8
9	c. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										9
10											10
11											11
12											12
13								TOTAL	$ 18,420		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Alden Management Services, Inc.
Street Address: 4200 W. Peterson Ave.
City / State / Zip Code: Chicago, IL 60646
Phone Number: (773) 286-3883
Fax Number: (773) 286-3743

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		see page 8A (also on page 6A)				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Proforma allocation of						$	$			$	1
2	interest expense prior to											2
3	sale/leaseback		x	mortgage	$15,474.67	3/7/75	2,166,900	1,576,876	8/20/17	8.2500	132,499	3
4												4
5												5
	Working Capital											
6	Related Party - AMS	X		Working capital							33,607	6
7	Related Party - FECII	X		Working capital							120	7
8	Related Party - CPT	X		Working capital							89	8
9	TOTAL Facility Related				$15,474.67		$ 2,166,900	$ 1,576,876			$ 166,315	9
	B. Non-Facility Related*											
10	interest income: gl 4646			offset expense w/income							(6)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (6)	14
15	TOTALS (line 9+line14)						$ 2,166,900	$ 1,576,876			$ 166,309	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 8,150 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	225,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	222,781	2
3. Under or (over) accrual (line 2 minus line 1).	$	(2,219)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	229,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	226,781	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	228,762	8
	1998	232,823	9
	1999	231,271	10
	2000	217,133	11
	2001	222,781	12

Accrual based on 3% increse over prior year bill.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden Morrow Rehab & HCC COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0019596

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE 773-286-3883 FAX #: 773-286-3743

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	2010-120-001-000	Nursing home facility	$ 27,847.58	$ 27,847.58
2.	2010-120-002-000	Nursing home facility	$ 27,847.58	$ 27,847.58
3.	2010-120-003-000	Nursing home facility	$ 27,847.58	$ 27,847.58
4.	2010-120-004-000	Nursing home facility	$ 27,847.58	$ 27,847.58
5.	2010-120-005-000	Nursing home facility	$ 27,847.58	$ 27,847.58
6.	2010-120-006-000	Nursing home facility	$ 27,847.58	$ 27,847.58
7.	2010-120-007-000	Nursing home facility	$ 27,847.58	$ 27,847.58
8.	2010-120-008-000	Nursing home facility	$ 27,847.58	$ 27,847.58
9.		Related Party - Alden Management	$ 76,052.00	$ 2,591.00
10.		Related Party - Forum	$ 8,608.00	$ 37.00
		TOTALS	$ 307,440.64	$ 225,408.64

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior brick Frame steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	nursing home		1974	$ 80,500	1
2					2
3	TOTALS			$ 80,500	3

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	192		1976	1976	$ 1,860,675	$	30	$ 62,023	$ 62,023	$ 1,609,519	4
5			1976	1976	147,556		30	4,919	4,919	128,578	5
6	Related Party-Forum			1978	18,359		22			18,359	6
7											7
8	Related Party-Forum Extended Care										8
	Improvement Type**										
9	ELEVATOR			1976	70,500		25			70,500	9
10	AIR CONDITIONER/PAINTING/SMOKE DRAPERIES			1978	14,584		4,7 & 8			14,584	10
11	DOOR/ESECT REPAIR/PANELS			1979	3,382		4 & 8			3,382	11
12	PAINTING			1981	7,954		3 & 5			7,954	12
13	PAINTING/ELECTRICAL WIRING/ELEVATOR REPAIR/A/C			1982	20,715		3,6,8 & 10			20,715	13
14	CHIMNEY/BASEBOARDS			1983	8,216		10 & 18			8,216	14
15	HOT WATER SYSTEM			1984	4,288		10			4,288	15
16	WALL/HANDRAIL/PLUMBING/ELECT REPAIR/PAINT/HVAC			1985	33,370		3,10 & 20			33,370	16
17	HEATING/PAINTING/MISC. REPAIR			1986	33,351		3,4,5,10&20			33,351	17
18	REPLACE CLOSET DOORS			1991	2,201		5			2,201	18
19	LOCKS/ROOFING			1994	9,675	968	10	968		7,901	19
20	REPLACE LEAKING PUMP			1995	2,057	137	15	137		1,051	20
21	WASCOMAT WASHTOWN			1987	2,175		3			2,175	21
22	WHEELCHAIR REPAIR/PLUMBING/PAINTING/CARPENTRY			1988	35,223		5 & 10			35,223	22
23	PLUMBING/MISC. REPAIRS			1989	21,020		5			21,020	23
24	ELEVATOR REPAIR			1990	2,900		5			2,900	24
25	REPLACE BLOWER MOTOR/FREEZER/CONDENSOR/BOILER			1991	22,644		5			22,644	25
26	FIRE ALARM/REPAIR PUMP/ELEVATOR REPAIR/MISC.			1992	30,274	268	5,10 & 15	268		29,284	26
27	REPAIR 3-WAY VALVES/AIR CONDENSOR/CAULKING/MSC			1993	14,638		5			14,638	27
28	ROOFING			1994	12,070	1,207	10	1,207		10,257	28
29	CONTROLS/PIPING/ROOF/VALVES/AC MOTOR & PUMP/MSC			1995	58,213	1,828	5,10,15&20	1,828		46,732	29
30	BOILER LEAKING & REPLACE TUBES			1996	7,674	512	15	512		3,411	30
31	BOILER TUBE			1996	5,700	380	15	380		2,407	31
32	BOILER TUBE			1996	5,699	380	15	380		2,343	32
33	HVAC			1996	238,155	9,526	25	9,526		59,539	33
34	INSTALL ELECTRICAL WIRING FOR DRYERS			1996	1,838		5			1,838	34
35	ABC-drywall for dryers			1996	1,105		5			1,105	35
36	TOTAL (lines 4 thru 35)				2,696,210	15,205		82,147	66,942	2,219,483	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Totals from Page 12, Carried Forward		$ 2,696,210	$ 15,205		$ 82,147	$ 66,942	$ 2,219,483	37
38	INSTALL SPRINKLER HEADS	1998	1,879	376	5	376		1,723	38
39	REPAIR FREON LEAKS	1998	5,391	1,078	5	1,078		4,942	39
40	REPAIR CHILLER	1998	4,930	493	10	493		2,218	40
41	REPAIR CONVECTION STEAMER	1998	2,230	223	10	223		985	41
42	ELECTRICAL WORK	1998	1,901	190	10	190		824	42
43	AIR CONDITIONERS	1998	68,504	4,567	15	4,567		19,790	43
44	AIR CONDITIONERS	1998	10,000	667	15	667		2,889	44
45	INSTALL DOOR RESTRICTOR	1998	3,400	652	20	652		822	45
46	ABC-CONCRETE PATIO	1999	7,346	735	10	735		2,326	46
47	Atash Fire & Safety Equipment (install alarm)	1999	12,400	827	15	827		3,307	47
48	Climate Service (repair leaks and air/water heating)	1999	10,519	701	15	701		2,805	48
49	Alden Bennett Construction(general construction)	1999	2,648	265	10	265		883	49
50	Climate Service(repair)	1999	1,676	112	15	112		363	50
51	Climate Service (repair pipes)	1999	1,565	104	15	104		330	51
52	Alden Bennett Construction(general construction)	1999	922	184	5	184		568	52
53	Alden Bennett Construction(general construction)	1999	6,329	633	10	633		1,951	53
54	Alden Bennett Construction(general construction)	1999	3,598	360	10	360		1,109	54
55	Alden Bennett Construction(general construction)	1999	4,089	409	10	409		1,261	55
56	Security Services Group(window detector system)	1999	4,687	312	15	312		989	56
57	CSI-fixed leaking coil	1998	3,526	705	5	705		822	57
58	ABC-various leasehold improvements	1999	45,440	4,544	10	4,544		13,632	58
59	Climate Service Inc (repair HVAC)	2000	1,696	113	15	113		339	59
60	Climate Service Inc (repair HVAC)	2000	2,283	152	15	152		457	60
61	Climate Service Inc (repair HVAC)	2000	1,509	94	16	94		283	61
62	GT Mechanical Inc	2000	5,000	333	15	333		889	62
63	Alden Bennett Construction (general construction)	2000	11,602	1,160	10	1,160		2,997	63
64	Alden Bennett Construction (general construction)	2000	16,663	1,666	10	1,666		4,166	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,937,944	$ 36,861		$ 103,803	$ 66,942	$ 2,293,153	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,937,944	$ 36,861		$ 103,803	$ 66,942	$ 2,293,153	1
2	Fox Valley (ansulator)	2000	2,007	201	10	201		485	2
3	CSI Coker Service (kitchen dishwasher)	2000	3,487	349	10	349		727	3
4	Alden Bennett Construction	2000	4,436	444	10	444		1,146	4
5	Alden Bennett Construction	2000	7,346	735	10	735		1,836	5
6	Alden Bennett Construction	2000	21,382	2,138	10	2,138		5,346	6
7	Alden Bennett Construction (leashold imprv.)	2000	8,803	880	10	880		2,421	7
8	Long Elevator (replace elevator cable)	2001	2,650	265	10	265		375	8
9	Long Elevator (replace elevator cable)	2001	2,650	265	10	265		353	9
10	Capps (install new water pipes in basement)	2001	4,400	176	25	176		249	10
11	Equipment Internt'l (Drier repair)	2001	1,178	236	5	236		314	11
12	Equipment Internt'l (Drier repair-parts for above repair)	2001	114	23	5	23		30	12
13	GT Mechanical (install exhaust fan: dishwasher)	2001	4,400	440	10	440		587	13
14	Sentry Protection (2 smoke detectors-boiler room)	2001	1,576	158	10	158		223	14
15	Capps plumbing (three cast pipes)	2002	1,765	177	10	177		177	15
16	Health care products (eleven wheel chair repairs)	2002	1,599	266	5	266		266	16
17	Alden Bennett Construction (various major repairs - paint - maint)	2002	3,132	574	5	574		574	17
18	F.E. Moran, Inc (21 smoke detectors)	2002	7,650	893	5	893		893	18
19	Long Elevator (replace elevator cable adjustment)	2002	(2,650)	(265)	10	(265)		(265)	19
20	GT Mechanical (motor exhaust - speed controller)	2002	2,042	68	10	68		68	20
21	Sept A/P report (dishwasher pump)	2002	1,490	137	10	137		137	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,017,402	$ 45,019		$ 111,961	$ 66,942	$ 2,309,096	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,017,402	$ 45,019		$ 111,961	$ 66,942	$ 2,309,096	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,017,402	$ 45,019		$ 111,961	$ 66,942	$ 2,309,096	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,017,402	$ 45,019		$ 111,961	$ 66,942	$ 2,309,096	1
2									2
3	Related Party-Forum:								3
4	Leasehold Improvement-Remodeling	1980	19,335		20			19,335	4
5	Leasehold Improvement-Remodeling	1980	1,208		10			1,208	5
6	Leasehold Improvement-Remodeling	1986	645		5			645	6
7	Leasehold Improvement-Remodeling	1990	404		5			404	7
8	Leasehold Improvement-Remodeling	1991	94		5			94	8
9	Leasehold Improvement-Remodeling	1993	8,304	830	10	830		8,304	9
10	Leasehold Improvement-Remodeling	1993	6,504	469	9.7	469		6,504	10
11	Leasehold Improvement-sign	1994	261	22	12	22		174	11
12	Leasehold Improvement-dryvit	1995	443	44	10	44		310	12
13	Leasehold Improvement-new ac	1999	723	48	15	48		145	13
14	Leasehold Improvement-roof	1985	972	52	19	52		922	14
15	Leasehold Improvement-roof	1994	863	58	15	58		518	15
16	Leasehold Improvement-roof	1997	819	55	15	55		328	16
17	Leasehold Improvement-roof	1998	1,390	93	15	93		464	17
18	Leasehold Improvement-parking lot asphalt	2000	111	11	10	11		33	18
19	Leasehold Improvement-hallway lighting	2001	155	16	10	16		32	19
20	Leasehold Improvement-DAI	2001	195	19	10	19		38	20
21	Leasehold Improvement-bathrooms	2002	687	69	10	69		69	21
22	Leasehold Improvement-Remodeling	2002	98	20	5	20		20	22
23	Related Party-AMS:								23
24	Leasehold Improvement-Remodeling	1993	4,266		7			4,266	24
25	Leasehold Improvement-Remodeling	1994	2,112		7			2,112	25
26	Leasehold Improvement-Remodeling	2002	5,221		7				26
27									27
28									28
29									29
30									30
31									31
32	Related Party-Forum Ext. Care	1999	1,764	28		28		183	32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,073,976	$ 46,853		$ 113,795	$ 66,942	$ 2,355,204	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 355,171	$ 32,934	$ 32,934	$	varies	$ 233,853	71
72	Current Year Purchases	12,498	989	989		varies	989	72
73	Fully Depreciated Assets	133,458	579	579		varies	133,458	73
74								74
75	TOTALS	$ 501,127	$ 34,502	$ 34,502	$		$ 368,300	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	car engine, van/ bus	'98- 02 Dodge	'98-'02	$ 12,336	$ 3,792	$ 3,792	$	3	$ 9,992	76
77										77
78										78
79										79
80	TOTALS			$ 12,336	$ 3,792	$ 3,792	$		$ 9,992	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,667,939	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 85,147	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 152,089	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 66,942	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,733,496	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$ n/a	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Omega Healthcare Investors

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [x] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		192	10/29/86	$ 0	10	5	3
4	Additions							4
5								5
6								6
7	TOTAL		192		$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [x] YES [ ] NO Terms: right of first refusal *

10. Effective dates of current rental agreement:
Beginning 10/31/01
Ending 10/31/06

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$ 581,420
13.	/2004	$ 581,420
14.	/2005	$ 581,420

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 8,598 Description: copy machine lease
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Various	Various	$ 958.17	$ 11,498	17
18					18
19					19
20					20
21	TOTAL		$ 958.17	$ 11,498	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   Skilled nurses on site

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 26,009	$		$ 26,009	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			1,820			1,820	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			21,007			21,007	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	SEE PAGE 16A	# of prescrpts			9,651			9,651	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	SEE PAGE 16A				(1,285)			(1,285)	13
14	TOTAL			$		$ 57,202	$		$ 57,202	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Alden Morrow Rehab & HCC **#** 0019596 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2002 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 119,381)	502,736		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	10,443		6
7	Other Prepaid Expenses	59,461		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): due from IDPA	54,122		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 626,762	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,006,585		15
16	Equipment, at Historical Cost	408,563		16
17	Accumulated Depreciation (book methods)	(853,132)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 562,017	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,188,779	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 238,368	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	134,798		28
29	Short-Term Notes Payable	28,905		29
30	Accrued Salaries Payable	134,536		30
31	Accrued Taxes Payable (excluding real estate taxes)	453,827		31
32	Accrued Real Estate Taxes(Sch.IX-B)	229,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to IDPA / accrued expenses.	75,627		36
37	Due to affiliates	955,176		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,250,237	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	75,770		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 75,770	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,326,007	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,137,228)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,188,779	$	48

***(See instructions.)**

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (183,353)	1
2	Restatements (describe):		2
3	external audit adjustments made after 2001 cost report was	33,055	3
4	submitted. These have no effect on prior years report:		4
5	Bad debt, medicare revenues (non-allowables)		5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (150,298)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(986,930)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (986,930)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,137,228)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,234,600	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,234,600	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	1,346	5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,346	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	14	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 14	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	write off of old accounts payable	3,062	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,062	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,239,027	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	851,370	31
32	Health Care	993,657	32
33	General Administration	1,549,385	33
	B. Capital Expense		
34	Ownership	989,090	34
	C. Ancillary Expense		
35	Special Cost Centers	85,814	35
36	Provider Participation Fee	105,120	36
	D. Other Expenses (specify):		
37	Related party salary allocations	(348,479)	37
38	located in column 1, schedl V.		38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,225,957	40
41	**Income before Income Taxes (line 30 minus line 40)****	(986,930)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (986,930)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	408	440	$ 13,882	$ 31.55	1
2	Assistant Director of Nursing	2,307	2,403	79,143	32.94	2
3	Registered Nurses	6,297	6,578	170,967	25.99	3
4	Licensed Practical Nurses	9,873	10,805	201,195	18.62	4
5	Nurse Aides & Orderlies	38,042	40,936	327,702	8.01	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,024	2,213	19,330	8.73	9
10	Activity Assistants	2,519	3,031	25,432	8.39	10
11	Social Service Workers	1,836	2,080	30,936	14.87	11
12	Dietician					12
13	Food Service Supervisor	2,194	2,553	31,175	12.21	13
14	Head Cook	5,238	5,898	49,292	8.36	14
15	Cook Helpers/Assistants	10,528	11,483	89,253	7.77	15
16	Dishwashers					16
17	Maintenance Workers	1,872	2,080	26,785	12.88	17
18	Housekeepers	12,666	13,892	105,615	7.60	18
19	Laundry	5,477	5,961	40,584	6.81	19
20	Administrator					20
21	Assistant Administrator	72	80	3,162	39.53	21
22	Other Administrative	643	1,015	18,801	18.52	22
23	Office Manager					23
24	Clerical	4,301	4,627	38,847	8.40	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,933	3,013	61,205	20.31	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Security	575	575	4,675	8.13	33
34	TOTAL (lines 1 - 33)	109,805	119,663	$ 1,337,981 *	$ 11.18	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 6,500	10-3	35
36	Medical Director	Monthly	12,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,608	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	41	2,166	11-3	44
45	Social Service Consultant	16	862	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	57	$ 26,136		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Mitchell, S	administrator	0	51,887
Osemwngie, I	administrator	0	39,000
various executives/assist admin	executive admin	0	53,472
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 144,359

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
AMS	Management Fees	$ 622,080
BDO Seidman	Accounting Fees	13,222
Ken Fisch / Greenberg	Legal Fees	16,312
Law Off. Of Chi. & J. Herman	Legal Consult.	5,847
Medi.com	Biling Consult.	321
Various Prof. Fees	Miscell.	554
US Gas & Energy	Utilites	1,728
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 660,063

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 41,700
Unemployment Compensation Insurance	12,432
FICA Taxes	106,964
Employee Health Insurance	21,641
Employee Meals	20,129
Illinois Municipal Retirement Fund (IMRF)*	
Related party - FECII	115
Union Health & Welfare	47,374
Dental, Life & Pension Costs	12,947
Relations, Misc., Tuition & Background Cks	1,413
Drug Tests and 401k Match	1,025
Related Party - AMS	45,734
TOTAL (agree to Schedule V, line 22, col.8)	$ 311,473

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Surety Bond Fees and Dues & Sub.	587
Il. Health Care Assoc	10,147
Related Party - AMS	260
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,995

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Misc/Gas/Repairs	333
Related Party - AMS	7,728
Seminar Expense	
Comprehensive Therapeutics	1,500
O.C.C. / Life Serv. Network & Misc	460
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,021

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	hvac/painting	1-10/89	$ 36,448	5	$	$	$	$	$	$	$	$	$
2	hvac repair	8/90	2,612	5									
3	hvac/painting/boiler rep's.	6-11/92	18,988	3-15	224	224	224	224	224	224	224	224	93
4	pump/paint./compress.	1-10/93	32,016	3									
5	painting/pump repairs	2-11/94	10,007	3									
6	painting	4-12/95	7,922	3	0								
7	hvac/pipes/boiler/paint'g	1-12/96	61,716	3-20	5,092	2,579	1,831	1,831	1,831	1,831	1,831	1,831	1,831
8	hvac repairs	1-12/97	22,597	3	7,532	2,872	0						
9	replace actuator/hvac	9/98	1,872	3	624	624	416	0					
10	repair a/c-Chic. Cool'g	10/99	3,529	3	294	1,176	1,176	882					
11	GT Mechanical (repair Va	5/00	2,168	3		482	723	723	240	0			
12	Alden Bennett (painting)	4/00	14,701	3		3,675	4,900	4,900	1,226	0			
13	Alden Bennett (landscapi	4/00	1,337	3		334	446	446	111	0			
14	GT Mechanical	10/00	2,949	3		246	983	983	737	0			
15	GT Mechanical (repairs)	3/02	2,479	3				689	826	826	138		
16	painting > $1,500 YTD	7/99	14,444	3	2,407	4,815	4,815	2,408					
17	painting > $1,500 YTD	7/00	7,887	3		1,315	2,629	2,629	1,315				
18													
19													
20	TOTALS		$ 243,673		$ 16,173	$ 18,342	$ 18,143	$ 15,715	$ 6,510	$ 2,881	$ 2,193	$ 2,055	$ 1,924

Facility Name & ID Number Alden Morrow Rehab & HCC **#** 0019596 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? yes

(2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. IL Healthcare Assoc. $10,147

(3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 6 yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 7,256 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? yes
If YES, give effective date of lease. 10/29/86

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 105,120
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 20,129 Has any meal income been offset against related costs? n/a Indicate the amount. $ n/a

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? n/a
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? n/a
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: BDO Seidman, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. not yet complete

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.